❑ Memorial Campus ❑ Sierra Campus ❑ East Campus ❑ Transmountain Campus

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department/**Ext \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home/Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signs & Symptoms of Tuberculosis**

□ Yes □ No Have you lost unexplainable weight in the last 6 months without dieting? If yes, how much? \_\_\_\_\_\_\_\_\_\_

□ Yes □ No Are you experiencing a loss of appetite? If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Do you on a regular basis have unexplainable night sweats or wake up with the sheets wet from sweating?

If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Do you have a frequent persistent cough? If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Are you bothered by being tired all the time? If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Are you bothered by shortness of breath? If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Do you cough up blood? If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Have you been having increased temperature? If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

□ Yes □ No Have you ever had a positive TB Skin or blood test? If yes, year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Have you ever taken medication to prevent or treat TB, e.g., isoniazid (INH) or rifampin?

□ Yes □ No Have you ever had BCG vaccine? If yes, year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Have you ever had TB disease diagnosis? If yes, year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Yes □ No Have you had a live virus vaccine in the past 4 weeks? If yes, wait 4 weeks.

□ Yes □ No Have you had a recent viral illness? If yes, wait 2 weeks.

□ Yes □ No Are you taking immunosuppressive drugs? If yes, consider 5mm positive.

□ Yes □ No Do you have any health conditions or take medications that might affect your immune system (e.g. steroids,

HIV/AIDS, organ transplant, chemotherapy, severe chronic illness) If yes, consider 5mm positive

**Travel History**

Yes No Were you born in the US? If no, where? \_\_\_\_\_\_\_\_\_\_\_ When did you come to the US?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Since your last screening, have you traveled outside the country? When/where/how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand if I should experience any of the signs & symptoms of tuberculosis above at any time during the year, I will contact Occupational Health immediately. I understand if the TB Skin test reaction is not read in 48 to 72 hours after its administration, it will have to be repeated.By signing this form I consent to receive a Tuberculin Skin Test, to comply with employment requirement.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* Test Administrator Only \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

Single TST: Manufacturer: \_Sanofi\_ Lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Exp.: \_\_\_\_\_\_\_\_\_\_

Site: Intradermal Forearm □ Right □ Left Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_

Induration: \_\_\_\_\_\_\_mm Read by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_

Two-Step TST: Manufacturer: \_Sanofi\_ Lot #: \_\_\_\_\_\_\_\_\_\_\_\_ Exp.: \_\_\_\_\_\_\_\_\_\_

Site: Intradermal Forearm □ Right □ Left Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_

Induration: \_\_\_\_\_\_\_mm Read by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Time: \_\_\_\_\_\_\_\_\_

IGRA results:\_\_\_\_\_\_\_\_\_\_ CXR Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Negative □ Positive

Consult Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Physician: □ N/A □ Yes Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral to Health Department\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_